



The Changing Face of Cancer Care: Evolution to a Collaborative Model

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Oncology has never been more exciting, or more challenging. At long last, the fruits of many years of labor in research investigating the basic science of cancer are being realized through genomic-based diagnostics and therapeutics as well as through highly active, novel immunotherapy. At the same time, the cost of medical care has skyrocketed, with cancer costs leading the way. In fact, the cost of care per patient with cancer exceeds that of all other medical conditions. Given the aging of the US population and the number of people diagnosed with cancer, this clinical burden adds up to a very large healthcare bill. Serious questions abound regarding whether the money is being spent wisely and whether value is being delivered. Certainly, the delivery of cancer care has room for improvement, and this improvement can increase the quality of care and reduce the cost of care.

The Institute of Medicine has estimated that up to 30% of our nation's healthcare spending is wasteful.¹ Most of this waste is in areas of low-value, redundant, or futile care.¹ It is safe to say that similar waste occurs in oncology care. For example, the cost is often lower for newly diagnosed patients as opposed to patients with recurrent disease, especially those in the last 6 to 12 months of life. Indeed, there is a disproportionate increase in hospitalization costs for symptoms of advanced malignancy at the end of life. Hospice services clearly reduce this pattern of care, and hospice use has increased. Still, almost half of all hospice-appropriate patients with cancer never receive this service.²⁻⁴

The cost of novel agents to treat cancer has become front-page news. Many of the new medications recently approved by the US Food and Drug Administration are targeted for subsets of patients with a specific molecular marker. Many of these agents are also oral, and cost more than \$100,000 annually. At the June 2013 American Society of Clinical Oncology annual meeting, novel immunotherapies to treat melanoma, a notoriously difficult cancer to treat, generated tremendous excitement. It has been theorized that these novel agents will be used in combination and may actually cure a subset of patients—but with a projected price tag of close to \$200,000 for an average course of treatment. So how can

we ensure that we offer these highly active therapies to our patients, while confronting the challenges of uneven quality and uncontrolled costs of care?

Quality Improvement

The answer may be as simple as approaching cancer care delivery as a continuous quality improvement process. To some extent, many oncology practices are already doing this. But the standardization of care, first by identifying and measuring the processes involved, followed by implementation of a quality improvement plan, then followed by measurement, will allow an individual practice to improve over time. In addition, standardization of care will allow benchmarking of practices to identify quality providers. Because the data needed to execute this strategy currently reside partially with providers and partially with payers, moving forward will require collaboration between providers and payers.

One way to move forward is to use clinical decision support tools, such as clinical pathways, as an enabling technology. These tools capture individual data and can identify clinically important subsets of patients, can report prospectively on compliance with evidence-based treatment guidelines, and can potentially link this information to downstream outcomes and resource consumption. Since the introduction of the National Comprehensive Cancer Network Clinical Guidelines®, evidence points to an increase in adherence to evidence-based treatment⁵; however, decision support tools provide additional value, because they can facilitate reporting and identify opportunities for improvement.

Provider–Payer Collaboration

Once the lines of communication open up between providers and payers, and practices become comfortable with process improvement, other collaborative projects become possible. One such approach is the oncology patient-centered medical home. This treatment delivery reform focuses on transforming the oncology care delivery model, using patient-centered care, evidence-based treatment, enhanced services, and shared decision-making as the cornerstones. Under this model, quality improves. Practices also will control costs by eliminating unneces-

sary emergency department visits and hospitalizations. Because of the enhanced care team–patient relationship, practices will more successfully address the difficult concerns surrounding quality-of-life and end-of-life issues.

The role of the payer is to facilitate data exchange, participate in discussions with engaged practices about opportunities for improvement, and perhaps most important, restructure payment to reward successful practices.

This evolution in the processes of care will prepare oncology practices to survive, and even flourish, in the new world of integrated delivery systems and accountable care organizations. These transformed practices will be the exact partners in care who will be sought out by these delivery systems.

The Patient

Patients must not get lost in transition. All of the reforms mentioned above will need to occur while preserving the best aspects of the patient–oncologist relationship. If the reforms are executed well, this relationship will be strengthened. Equally important, there will be new opportunities for transparency regarding quality. Patient satisfaction and measurable outcomes will be required. Finally, patients will be able to participate in healthcare as informed decision makers.

Facing the Challenges

There are surely challenges. The average oncology practice consists of 4 physicians. Providing enhanced

services simply may not be possible. To fill this gap, payers may develop enhanced patient services in collaboration with providers. These services may include a more focused case management approach, such as a virtual patient navigator, or a dedicated end-of-life support team. Even more challenging may be the electronic interfaces that will be required for real-time decisions and patient support.

The fact that multiple payers may bring many solutions could prove daunting for any individual practice. The move to transparent cost and quality reporting will require a massive cultural transformation for patients, providers, and payers. These challenges should not derail the efforts to improve the quality and value of care. Never have the potential benefits to providers, payers, and, most important, patients been greater. ■

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